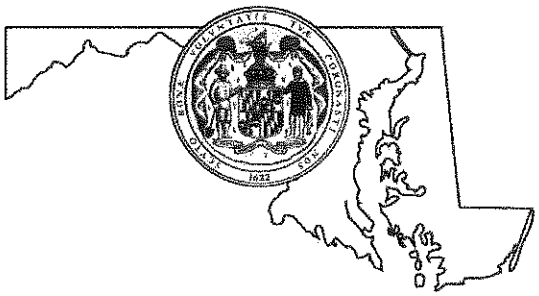

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Memorandum

Date: September 21, 2016

To: Robert E. Moffit, Ph.D.
Commissioner/Reviewer, MHCC

From: Donna Kinzer, Executive Director
Gerard J. Schmith, Deputy Director, Hospital Rate Setting, HSCRC

Subject: Modification of Application for Certificate of Need to Relocate Prince George's Hospital Center (Docket No. 13-16-2351)

On September 8, 2016, you requested that we review and comment on certain aspects of the financial feasibility and underlying assumptions of the modified Certificate of Need ("CON") application submitted by Dimensions Health System ("Dimensions," or "DHS") on August 31, 2016. The application concerns the proposed relocation of Prince George's Hospital Center ("PGHC").

Per your request we will address each of the five specific questions outlined in your letter.

1. *Are the sources of funds assumed by the applicants appropriate? In your opinion, is the proportion of non-debt and non-grant sources of project funding adequate?*

PGHC has assumed the following sources of funds for their project as reported to the HSCRC:

Source:	Amount
Authorized Bonds	$117,809,717
Interest Income from Bond Proceeds	9,190,283
State Grant	208,000,000
County Grant	208,000,000
Contribution of Land by County	12,350,000
Total Sources of Funds	$555,350,000

The $12,350,000 reported as "Contribution of Land by the County" as a source of funds also appears as a use of funds in the CON modification as "Land Purchase," so no cash is required to be paid. We do not know if the assessed value of $12,350,000 is reasonable.

The sources of funds assumed by the applicants appear appropriate with the understanding that the County and State will provide the funds in the amounts shown above. Beyond the funds granted and the land contributed, DHS must borrow the balance of funds needed, since it has no excess cash reserves to contribute to the project. In fact, DGH will need to borrow money for the short term in order to ensure that an adequate number of Days of Cash on Hand are available, which may be required in the bond documents.

2. *The applicants have assumed that a "redistribution" of the Dimension's Health System's global budget revenue will be a source of revenue needed by PGHC to successfully relocate and transition to operation of a new replacement hospital, in lieu of the partial rate request revenue adjustment for capital that it has been pursuing to date. This would appear to be related to the plan announced by Dimensions in 2015 to convert the Laurel Regional Hospital campus to an outpatient health care facility by 2018. In your opinion, is this a reasonable and acceptable approach to increasing PGHC's revenue in the amount necessary for this project to be feasible and the replaced and relocated PGHC to be financially viable? Is it a preferable option to the current partial rate request revenue adjustment for capital that Dimensions has filed with the HSCRC? If, in your opinion, this redistribution is not necessary for project feasibility and the viability of PGHC, please provide the basis for this opinion.*

We have reviewed DHS's plan to redistribute the System's Global Budget Revenue (GBR) among PGHC, Laurel Hospital, and the Bowie Health Center. The plan proposed by Dimensions would provide PGHC with a greater revenue increase ($30 million) than requested in the partial rate application for additional capital ($25 million) previously submitted by PGHC. As will be discussed in the response to question # 4, PGHC's rates after the redistribution of revenue to PGHC will be 25% to 30% above its neighboring competitor hospitals.

HSCRC staff believes that reallocating resources within a system is a preferable approach and is consistent with the All Payer Model goals. By restructuring resources within a system, funds are freed up to fund transition and ongoing resource needs of the system, inclusive of support of the new facilities. Through this mechanism, the project does not add additional cost to the healthcare system as a whole. We have worked with other healthcare systems over the last few years to allow for the reallocation of resources, as they have moved services and providers from one campus to another. This flexibility promotes the goals of better care and lower costs.

Whether the total $30 million is necessary is questionable given the level of the expenses DHS has built into its projections, and the fact that its rates are currently higher than other competitor and peer hospitals. However, there are some legitimate reasons for its higher rates than

competitors (as we will address in Question 4), and PGHC believes that it will become more competitive over time. There are also transition expenses, infrastructure and population health investments, and other expenses that will need to be funded. Also, DHS will be subject to efficiency measures, and if the level of funding is too high, it will be subject to adjustment.

3. *As with previous iterations of this project, Dimensions assumes that revenue adjustments for market shifts should be recognized immediately in the year of the volume growth resulting from the shift in market share rather than in the year following the volume growth. Will HSCRC agree to this treatment of market share shift-related volume increases?*

As stated above, HSCRC staff has been working with other healthcare systems to ensure that revenues are moved as expenses are incurred for planned moves of services from one facility within a system to another. If services are moved within DHS, the revenue would also be moved as soon as possible. The HSCRC staff has recently begun to implement rate changes for market shifts on a more current basis than we have in the past. Also, HSCRC has made other current market shift adjustments. For example, HSCRC implemented concurrent market shift adjustments when Holy Cross Germantown opened, and several facilities were adversely affected thereby. When HSCRC makes concurrent market shift adjustments, it subsequently corrects for differences between estimated and actual shifts. PGHC understands that if it does not achieve the projected market shift change, then an adjustment will be made during the subsequent year to recover the revenue advanced in anticipation of the market shift.

4. *Based on your analysis and the experience of the HSCRC to date in implementing the new payment model for hospitals, what is the ability of the proposed replacement to be competitively priced, when compared with general hospitals in its region of the State and when compared with similar (peer group) hospitals throughout the State, if the project is implemented as proposed and the applicants' utilization projections are realized?*

We remain concerned that the projected unit rates for PGHC will be well above other general hospitals in its region as well as in similar peer group hospitals throughout the State.. Listed below are the projected inpatient revenue, inpatient discharges, inpatient revenue per discharge, and the annual percentage increase in inpatient revenue per discharge for PGHC for the years ended June 30, 2016 through June 30, 2023 per the inflated projected financial statements included in the CON:

Year Ended June 30	Inpatient Revenue (in 000's)	Inpatient discharges	Inpatient Revenue Per Discharge	Percentage Annual Increase
2016	$214,979	12,306	$17,469	
2017	222,540	12,417	17,922	2.6%

2018	230,168	12,573	18,306	2.1%
2019	263,213	12,730	20,677	13.0%
2020	272,654	12,886	21,159	2.3%
2021	283,965	13,185	21,537	1.8%
2022	294,605	13,484	21,848	1.4%
2023	304,262	13,783	22,075	1.0%
Total				24.2%

On Page 53 of PGHC's request to redistribute GBR revenue submitted to the HSCRC on July 27, 2016, PGHC stated that its rates were on average 19.5% above the other general hospitals within its region. Assuming that the other hospitals in PGHC's region are granted approved increases in revenue of 2.3% annually for the 7 years ending June 30, 2023, their rates would increase by 16.1% compared to the 24.2% projected by PGHC. If we were to add the 8.1% difference between PGHC's projected increases and the other hospitals' projected increases to the existing 19.5% difference in rates, then PGHC's rates would be on average 27.6% higher than the other hospitals in its region by the end of the projection period in the CON. While DHS has projected an increase in volumes at a variable cost rate of 50%, the increase in volume is not sufficient to significantly reduce the PGHC's prices.

The original CON modification submitted January 16, 2015 projected a significantly higher percentage increase in annual volumes than the August 31, 2016 CON modification. Listed below are the projected discharges from the January 16, 2015 CON filing compared to the projected discharges in the August 31, 2016 CON modification:

	Year Ended June 30,				
	2019	2020	2021	2022	2023
January 16, 2015 CON Modification Discharges	12,081	12,993	13,905	14,817	N/A
Annual Percent Increase	1.4%	7.5%	7.0%	6.6%	
August 31, 2016 CON Modification Discharges	12,701	12,886	13,184	13,484	13,783
Annual Percent Increase	1.3%	1.5%	2.3%	2.3%	2.2%

In January 2015, PGHC had projected that it would have 10% more discharges than it is now projecting for 2022. If PGHC had not reduced the projected 2022 volumes between the January 2015 CON submission and the August 31, 2016 CON submission and had held projected revenue constant, PGHC's projected 2022 revenue per discharge would have been 5% to 10% lower than the amount projected in the August 31, 2016 CON submission.

Based on the projected inpatient revenue per discharge included in the current CON modification, PGHC does not appear to be competitively priced compared to the hospitals in region.

The HSCRC is currently developing comparisons of cost per capita to augment comparisons based on unit or per case prices. This may change the relative ranking of the PGHC facility. PGHC's current revenue per equivalent discharge on a calendar year-to-date basis through July 31, 2016 is approximately 12% higher than the average charges of a peer group of similar hospitals including MedStar Harbor Hospital, MedStar Union Memorial Hospital, Sinai Hospital, Mercy Hospital, and Johns Hopkins Bayview. By 2023, PGHC's projected charges per case would be approximately 20% higher than the peer group of hospitals after taking into account the redistributed System revenue and projected future volume changes at PGHC.

PGHC has a trauma service and has had a large share of indigent patients referred to as "Disproportionate Share" patients. Trauma services and higher costs related to health and socioeconomic costs of treating indigent patients serve to increase relative rates. We have not removed these costs from this analysis. These are severity and social costs that must be borne by Dimensions.

HSCRC staff will recommend that PGHC's rate structure be subject to efficiency measures developed by HSCRC staff in the future.

5. *I asked the applicants to provide a complete and detailed analysis of how this project will improve operational efficiency and reduce staffing hours and cost per unit of service. I asked them to quantify the financial impact of the projected operational efficiencies. Pages 17 through 30 of the August 31, 2016 filing responds to this request. I am interested in HSCRC's perspective on the strength of the case made by the applicants.*

We reviewed the performance improvements explained on Pages 17 through 30 of the August 31, 2016 CON modification. The first set of performance improvements relate to improved collection efforts by PGHC which will result in higher collections in the future. We believe that the collection improvements identified by PGHC are achievable and may actually result in even greater improvements in future collections than the amounts estimated by PGHC in the modification.

The second and third performance improvements identified by PGHC relate to reductions in overall length of stays as well as unnecessary admissions. Staff believes that the performance improvements related to reduced utilization are achievable and could potentially be higher. .

The fourth and fifth set of performance improvements identified by PGHC relate to reductions in salaries through improvements in recruiting efforts, management of staff, and improvements in supply chain management and drug and contract service cost reductions. In order to evaluate the estimated performance improvements in operational expense areas, we calculated the average annual percentage change in uninflated operating expenses per Equivalent Inpatient Admission. In our calculation of annual changes in operating expenses, we excluded from our analysis

changes in capital expenses and physician support expenses because these two items are not impacted by changes in volumes. The results of our analysis are presented below:

Projected Year Ended June 30,	Average Operating Expenses Per EIPA (Uninflated)	Percent Change from Prior Year
2016	$13,240	2.7%
2017	$13,163	-.6%
2018	$12,895	-2.0%
2019	$12,348	-4.2%
2020	$12,017	-2.7%
2021	$11,880	-1.1%
2022	$11,748	-1.1%
2023	$11,649	-.8%

Beginning in FY 2017, PGHC projected that the average operating cost per EIPA would decrease each year as expense performance improvements were implemented and volumes increased. Again, we believe that these operational expense performance improvements projected by PGHC are reasonable, and that actual improvements could be greater than anticipated.

In summary, we believe that the performance improvements identified by PGHC in their CON modification are achievable. Furthermore, we believe that PGHC will exceed the savings estimated from performance improvements, which will have a positive impact on the projected income statements.

Please contact us if you have further questions.